Progress Note
Agency Name
Agency Address

Identifying Information

Name: Age:
Client ID: Gender:
Parent or Legal Guardian:
Individual(s) present:

Service Rendered:
Setting of Service:
Start Time: End Time: Duration:
Therapeutic Modality:
Service Provider:

Session Goal:

Identify the goal for the session **Specific goals and objectives addressed in the treatment session**
Client progress towards completion of goals identified in the treatment plan
Barriers to client progress towards completion of treatment goals (Be sure to document any missed sessions or professional consultations regarding the client)
Identify the plan to address clients progress towards completion of identified treatment goals.

Plan:

Based upon the client's response to the treatment plan what may need revision
Plan for the next session and the scheduled date for that session

Licensed Therapist Signature: Date:
Include credential and title

Clinical Supervisor Signature: Date:
Include credential and title
(if necessary)

Progress Note Formats

If using the DAP progress note method include::

Data

Subjective data about the client (client's observations, thoughts, and quotes)

Objective data about the client (counselor's observations: affect, mood, behavior, appearance)

Content and process of the session

Home work reviewed in session

Assessment

Therapists understanding of the client's problems, working hypothesis, results of screening and assessment instruments, client's response to the treatment plan

Plan

Based upon the client's response to the treatment plan what may need revision

Specific goals and objectives addressed in the treatment session (make sure the note connects to the identified treatment goals identified in the mental health assessment, treatment plan and domestic violence treatment needs)

Plan for the next session and the scheduled date for that session

If using SOAP progress note method include:

Subjective

Subjective data about the client (client's observations, thoughts, and quotes)

Objective

Objective data about the client (counselor's observations: affect, mood, behavior, appearance)

Assessment

Therapists understanding of the client's problems, working hypothesis, results of screening and assessment instruments, client's response to the treatment plan

Specific goals and objectives addressed in the treatment session (make sure the note connects to the identified treatment goals identified in the mental health assessment, treatment plan and domestic violence treatment needs)

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